KNEPPER
CONCIERGE MEDICINE
ELEVATING HEALTHCARE, ONE PATIENT AT A TIME

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name	Patient's Date of Birth
Address Patient's	Telephone Number
City, State Zip Code	Any Other Names Used

I hereby request that Apex Concierege Medicine, LLC DBA Knepper Concierge Medicine use / disclose my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all):

   _____

2. Be sent to the following person / entity at the address listed:

   _____
   Name

   _____
   Address

   _____
   City, State Zip Code

3. I authorize disclosure of the following specific information (include dates of service):

_____

_____

_____

NOTE: UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
☐ YES, PLEASE DISCLOSE THIS INFORMATION: _____

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **Unless otherwise specified below, I understand that my PHI will be provided in paper format**. I hereby request that my PHI be provided in the following format:
☐ On an encrypted USB drive ☐ On an unencrypted USB drive ☐ Other (please specify) _____

5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.

6. I understand I may revoke this authorization by notifying Privia Medical Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

7. My purpose/use of the information is for ☐ personal use; ☐ or other (please specify) _____.

8. This authorization expires on _____ _____, 20_____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____.

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If the charges will exceed $25, we will inform you of the approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ Signature of Patient	_____ Date of Patient's Signature	_____ Patient's Date of Birth
_____ If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	_____ Date of Legal Guardian's/Personal Representative's Signature	_____ Description of Authority to Act for the Individual

For Privia Use Only

Date Received	**Date Processed**	**Format**	**Fee**	**Pt Notified of Fee**	**Medical Record #**
_____	_____	_____	_____	_____	_____